Transcription for Office Hours for Providers
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Hugh Tilson:
Let's go ahead and get started. Good afternoon, everyone, and thank you for participating in office hours for providers. We established these office hours a couple months ago to maintain communication channels between providers about COVID-19 and related activities. I'm the director of the NC AHEC program. The panelists are Dr. Betty Tilson and Dr. Zack Moore. And, today we're joined by a special guest, Maggie Sauer, who's the director of rural health. Just as a quick reminder, based on your feedback, the doctors have agreed to keep doing these office hours-- they're incredibly valuable. Please join me in thanking them for continuing to do this with their busy schedules. I will turn this over to Maggie in just a minute, but I want to thank everyone for participating. We know how valuable your time is and we hope it will help you do your important work and make navigating these challenges a little bit easier. For some logistics: after you hear from Betty, Zack, and Maggie, we will take your questions and you can use the Q&A feature at the bottom of the screen. We did get some questions in advance and we will turn to those as well. You can submit your questions through email: questionscovid19forum@gmai.com. There are links that will be helpful and we have updated the slides and we hope to get those posted on the website. Let me now turn it over to Maggie.

Maggie:
Thank you for joining us today. It is a pleasure to be here with all of you and thank you again for all of your hard work out in the field. This is a wonderful opportunity to tell you about some additional resources that have been developed to try to help pay for uninsured care for North Carolina residents. As you know, we have been trying to figure out a lot of ways for people to get access to care. There are a number of different programs that are available. Certainly, Medicaid reimburses for testing and as we know, residents need to get access to primary care. What this particular opportunity will provide is the opportunity to bill for an uninsured patient visit and it is COVID-related. I want to stress specifically that it could be a COVID-related event if someone had been employed, lost their healthcare insurance due to the pandemic and are now uninsured. So this is not just a safety net, but also working across other providers across the state, this is a statewide initiative-- not just rural-- but to create opportunities for patients that you have been seeing that require additional care, and/or patients that need a primary care home. This is part of the intent around the program. Again, the

reimbursement is linked to a time requirement. In other words, we have about $7.8 million that needs to be spent on these services, primary care services, not specialty care services, and we have until December 30th to do that. The program provides $150 for each eligible claim to primary care providers who are providing the service. I think it is important, when we have talked about this, people say it is just $150 for the care of that patient. No, it is $150 per encounter for a patient. So for example, if someone comes to your office, you are helping them with some issue related to their blood pressure or diabetes or whatever that might be, you can bill against this code that is going to be built into NCTracks, that will be $150 per encounter. Again, we hope that would cover most of the cost of those visits, but we are basing that logic on Medicaid assisted provider care. Which we run from our office, which is generally $100 per encounter. But in this case, we are able to offer the $150. It can be COVID-related services, and we are determining COVID related very broadly. If you have questions about what that looks like, feel free to reach out with those questions, but as we have been looking at the ability to prevent issues related to COVID that make historically marginalized populations more at risk for COVID-19, one of the goals around this is making sure that people can get to the care that they need to prevent COVID and help them be less susceptible to that. What we need to make sure of is that this visit is not eligible to be paid by any other insurance, Medicare/ Medicaid, or other insurance. There is an attestation form in NCTracks that will be required. There will be a portal in NCTracks, a separate area, that you or your practice manager can go to to bill for the visits. We will do training to show you what those screens look as we move forward towards launching this. The portal launch will be October 30th, so we have been trying to get the information out to folks. And I think it will be important to look at the attestation statement at the bottom of the screen as related to so many COVID-19 Cares Act dollars. We are being asked to be very clear that all the other opportunities for payments around these have checked the boxes, especially the HRSA portal. And for this particular opportunity, there is a place at the portal where you can enter a Social Security number. It is not required. It is available, but it is not required. I understand that can be difficult for some of our populations.

We imagine there might be people who are interested in this opportunity who heretofore have not been enrolled in the NCTracks portal. You can do that now to register to become a provider. We will be able to suggest that people hold claims backdated to September 1st, 2020, until the portal is live and at that time, those claims can be submitted on October 30th. We are, as I said, trying to look at many opportunities to get this information out to people so that people do not go without care. We can provide support to practices, practice managers, and patients to access this. You may also know about the Community Health Worker Project that the department has been working with across 50 communities. One of the goals of that project is to get people to primary care. And helping people navigate to the resources in a culturally appropriate way in their community and we hope that this opportunity will open more primary care access for people in their communities. We will continue to update you on this.

To give you an idea of the timeline, starting September 1st, if we look across the top of this slide, claims dated back to September 1st are eligible for payment as long as you follow all of the things that we just talked about and it qualifies for COVID funding. And we want to make sure that people hold those claims so they can submit them. This is one of the ways that we try to let people know about the opportunities that are out there and connect partners, whether they are community partners or physician partners, so it is something that can be utilized to its end. And we have all the money out the door which hopefully people are getting the care that they need. The end of the program is December 30th. Something I want to emphasize here is that at the portal and with the communications you will be seeing around this opportunity, we are going to post how the fund is being depleted, so to speak. So it is important, first come first serve and we will post additional comments and updates at the DHHS website and we will give you the link to that. We want you to know how quickly the money is being spent. The idea is as soon as you get a claim and the portal is opened, please submit that claim because we want to make sure that people are not holding claims

until November or December and then submitting them at once and perhaps finding out that the funds are no longer there because they've been depleted. Anyway that we can help you and answer questions, so we can help you, that would be important.
We do have some training opportunities around the portal that will come up and we have been working with our vendor to create those opportunities sooner than November 9th. We can update that as soon as we have more information, but we hope to start that by the 1st of November when the portal opens. We had looked at trying to do the training ahead of time, and what we were told is that a more effective way of training, instead of providing those shots of what the portal will look like, is by actually having the portal open so people can go through and they can experience it live. So we will continue to do that and there will be training on the website itself. Video clips that will be placed at unique places within the portal experience so that if there are issues or questions that come up. The webinars will be sent out, but there will be clips that will accompany different parts of the portal.

Hugh:
Thank you, Maggie. I got a couple questions in the Q&A and we remind you that you can use those. If you are on the phone, you can send us questions through email. These slides are on the NC AHEC website under office hours. **The only question we have gotten so far is can you register in NCTracks if you do not accept Medicaid or Medicare? This particular provider is self-pay services only and they don't bill insurers. And how can they participate in this?**

Maggie:
I will reach out to Betsey to make sure I'm answering this correctly. Even if you're not accepting patients, you can still go in and register because you're really not going to bill against Medicaid, you will be billing against this uninsured portal.

Betsey:
Betsey does not have the expertise to know that. We will have to check with the Medicaid team to check on the NCTracks specifics and who can register.

Maggie:
We can get back to you on that. One thing that I did neglect to mention is the department -- because there are so many of these opportunities that are out there and available for people, they are creating a two-page document. One that describes the different payment options that are available for folks, and the second one is kind of a chart that explains all that. The reason it is important is that the North Carolina Medical Society rolled out a portal as well, and that was opened yesterday on October 8th. There are $25 million available through that portal. You can bill that back to March of this year for uninsured services as well as -- it is not just primary care. It is also specialty care. The thing that is cool about that is that now you can get testing for uninsured patients. You can get a primary care visit paid for and now specialty care. You have this whole range of services that a patient can receive and you can be reimbursed for with that particular range of funds. The document talks about this portal, it talks about the Medical Society Portal, and the HRSA portal and the North Carolina Medicaid testing site. There is a lot out there and we want to make sure we can support that in whatever way possible.

Hugh:
Thank you, Maggie. We will see if we can get that information out about enrollment to confirm. Let me now turn it over to Betsey and Zack .

Zack:

Can you hear me? I was having challenges. Thanks, everybody, for joining. We would first like to give a quick snapshot of where we are in terms of COVID activity, which is that we are in a precarious place. We have seen an increase lately in our recorded cases and in some of our other metrics. We had a downward trajectory and a bump when Colleges came back in since the summer, but case reporting has increased over the past couple of weeks, fairly sharply. It does not appear to be driven, or at least not largely driven by increased testing, although we have had increased testing volume which is a good thing. It does not appear to be driven by any one particular region or demographic and what we are seeing is a combination of things driving transmission across the state. We are seeing community transmission without any identified specific exposure or linkages to outbreaks or clusters, and when we have been working with the local health department partners to understand what is happening, a lot of issues, which may not be surprising to you, with lack of compliance or with lack of enforcement of the mask mandate requirements of businesses and at gatherings and sort of transmission out in the community in various types of setting. And that also translates into increases in clusters and outbreaks that we are seeing, particularly where we have been having problems since the very beginning in congregants living facilities with long-term care, and skilled nursing facilities, also in some prisons and jails and other congregants living settings where the cycle of increasing transmission gets introduced into places where transmission is more difficult to control. This emphasizes the importance of prevention and of being as vocal and diligent as we can be to get those messages out there of the three Ws. There has been a consistent accumulation of studies and modeling about if we were able to achieve better mask compliance what the beneficial effects that might have in terms of reducing transmission. So learning more all the time, but it is not totally a surprise. Most every respiratory virus tends to increase seasonally. We have expected it was likely to happen, but I don't view it as inevitable that we will have uncontrolled increases if we can manage to reach people and emphasize the importance of the prevention messages.

A couple of other trend things. There is a lot of attention on schools. of course Some of those are transitioning back to hybrid or fully in person modes. We have not seen big increases thus far in school-aged children. We have seen an increase in clusters associated with schools, and those are posted on the website. Again, not a surprise when we have more people back in schools that we would start to see clusters. Early on those were predominantly or exclusively in staff members, but we are starting to see more clusters that involve more students in K-12 and disproportionately in private schools. Those tend to be the ones that are open more. That is something we are tracking carefully and, FYI, we just released an update to our strong schools toolkit with a lot of new information and guidance. If that is something that you are interested in, it is up on the website.

I will also say that the flu is a concern. We are seeing the flu out there, just sporadic so far, not really pinging in our influenza surveillance systems. We did post today our first combined COVID and influenza surveillance summary for those of you who have been aware of the flu surveillance summaries. Those are put out weekly between October and May. It is up on the COVID website and flu website so you can see what is happening there. The numbers of COVID in emergency departments has been ticking up. The COVID-like illness in ED is not dependent on testing volume, so it is good to see how that compares and we have seen an uptick in ED visits for COVID-like illness in that report. We have separated COVID-like illness and influenza-like illness and there is overlap, but it’s possible to do that. And, the influenza-like illness has not really been increasing lately.

Enough on the trends. The other topic that is consuming us is antigen testing, point of care antigen testing. We did just released a link to updated antigen testing guidance. There have been several new antigen tests that have received FDA emergency use authorization, and there have been a large number of these that have been procured by the federal government and distributed to the states and from us to the local health departments, in addition to the direct federal distribution to another siteslike nursing homes and historically Black colleges and universities. These are out there. We are trying to provide as much information as we can about appropriate use. The actual approved use for

these tests is in people with symptoms within the first 5 to 7 days, depending on the specific assay. They are being widely used and the federal government has basically said that they will accept and allow for the use of these tests for screening of asymptomatic people in certain situations. That is something that we are learning more about all the time. These are less sensitive tests, like a rapid flu test. You cannot rule out COVID with a negative antigen test if COVID is suspected.-- that is a known issue with these There are reports of false positives when they are being used, particularly for screening of asymptomatic people or high-volume screening of residents and staff in nursing homes or they are being used in colleges and universities in school settings for testing of asymptomatic people. At this point they are mostly anecdotal reports of false positive issues, although the state of Nevada did a small comparison of antigen and PCR results and they were concerned about a high false positive rate. They put out a notice that nursing homes should no longer use these for testing of asymptomatic people. A lot is going on there, but I would encourage you to look at the guidance and we have a table in there that talks about how to interpret the results and talks about certain settings where they could be used and talks about how to interpret the results in either people who are symptomatic or people who are asymptomatic. How to interpret positives and negatives in those situations. I would encourage you to look at that. I wish it were more straightforward, but there is some nuance there in terms of whether a confirmatory PCR test is or is not required based on your antigen test results. This short version would be if you are asymptomatic and have a positive result, you don't need a confirmatory result. If you're symptomatic with a negative result, you do need a confirmatory PCR because you can't rule it out based on that. If you are testing someone that does not have symptoms, but gets positive results, that person should be isolated, but we do recommend a confirmatory lab PCR. And an asymptomatic person that has no close contacts and has negative results does not require confirmation. Some of you may be procuring these tests in office settings and just a reminder that we do have a requirement for reporting of negative and positive results, including antigen, to the state and there is a link that became effective September 25th that spells out the requirement. We also have guidance that gets much more detailed on how to do that. We have tried to offer a range of reporting options down to as simple as completing a spreadsheet that can be password protected and sent to a dedicated email on up to registering for electronic laboratory reporting. Just an important reminder that those results are all reportable and to look at those reporting requirements if you are considering or already doing antigen testing in your practices. I think that is probably all I will say.

Betsey:
You can tell there is so much going on. I will do a high level about where we are with planning for COVID vaccine. I will not go into huge detail because I want to make sure we get to the questions you have submitted. Big picture, which we talked about a few weeks ago, Operation Warp Speed is the federal government initiative to try to accelerate vaccine production. Not so much the clinical trials. More like, planning for Phase 3 at the same time as planning for phase 1 and ensuring that they have a really high number of people in those clinical trials and not compromising on efficacy, but just making the process more efficient. And at the same time ramping up production at the same time as the clinical trials are going on so that whichever vaccine that we have efficacy and safety data, we have already begun production on those so there's no lag between data and production. What we know, there's 4 in clinical trials right now and what you may have seen this week is that the FDA did put out rules that there needs to be sufficient -- there was always the expectation of efficacy and at a minimum, vaccines need to be 50% effective. But they have made sure there are minimum safety standards. At least half of the people need to have two months beyond the second dose of the vaccine and have to have that data before they can be approved. Most vaccine adverse events happen within a month, and two months is basically in adverse reporting events, what they think would be counted as temporarily related to the vaccine. That came out this week, so that is a good thing. And then the other thing that came out from the federal government was the expectation that before a vaccine is

approved and released, there has to be the ability for mass production and to have a lot of volume. Based on that, I think the anticipation is that the earliest we would get some vaccine might be November, maybe December, but that is pushing back the timing of that and there would not be a lot of supply of the vaccine until 2021. So pushed back a little, but rightly so to ensure we have the right safety and efficacy data. They don't show the exact timing, but the sense I'm getting is it will be pushed back.

The second thing is that even though the production will be ramping up, the expectation is that it will not be that we will have enough for everybody in the beginning. So there will need to be prioritization. And that's something that we are working on now and we are aligning with the National Institute of Medicine and the CDC. What looks like the priority populations will be health care workers at high risk of exposure, long term care staff and residents, and then people with two or more chronic conditions that put them at high risk for COVID morbidity would be some of the initial priority groups. But setting the expectation that it will not be for everyone in the beginning. We are writing the plan, and it is due to the federal government for a week from today. We are going through an interim plan and we will have more information as we learn and we will update that plan. But a first draft of that plan will be submitted a week from today. We are working really closely and we have an external advisory committee through the NC Institute of Medicine that we have convened. Several of you may be on that. That group has helped us think through the prioritization schema for communication and outreach to stakeholders and it will be helpful to start thinking through operations and engaging our stakeholders in terms of actually getting to operationalize this plan.

One piece of critical importance is going to be communication. We expect there will be higher than usual vaccine hesitancy with this vaccine mostly because of the concern of the speed. And equating speed with efficacy, and this has been wrapped up in a political swirl. We anticipate that there will be vaccine hesitancy and we want to think about how to set up a foundation of trust. We are thinking through how we make sure we can communicate and transparency-- what we know and what we don't know.

The next piece is the first piece of concrete operationalizing of this will be enrolling providers to be COVID vaccinaters. You will have to enroll to deliver the COVID vaccine. As of this morning, our first provider enrollments went out and the health departments will be first and then we will look at the health systems and then more broader provider enrollment. That will be the first action step to be enrolled as a COVID vaccinater. I could talk about this for the next hour. But I'm happy to answer any questions. Those are the high-level pieces of where we are right now.

Hugh:

Thank you. We have a quick follow-up Zack to the electronic reporting spreadsheet. **Can you tell us more about that and will the state do that centrally or do we have to do that with each health department?**

Zack:

The state will do that centrally and we have put out a spreadsheet. I think so far, this has all sort of happened this week, but that has been sent out to long-term care facilities initially with the idea that it is an approach that can be expanded out to provider practices, etc. It was envisioned as a temporary thing until we can get people onto a more stable reporting mechanism. But it will go centrally. The rule for reporting says that laboratories must report to the state and providers report to their local health departments. But, and it's a really big but, the definition of laboratory basically includes any facility where testing is being done under a [indiscernible] qualification or a certificate of waivers. If you are doing testing with a certificate of waiver, you're considered a laboratory. So the majority of cases is to the state rather than the local health department.

Hugh:
Thank you. Let's talk about Betty's favorite holiday, Halloween. **We are getting questions from families about trick-or-treating. Many still will despite recommendations against it. What suggestions do you have to minimize risk?**

Betsey:
I have more than suggestions. We actually wrote Halloween guidance. Is up on our website. If you go on the website and click on guidance, and go to the Phase 3 easing of restrictions, you will see actual guidance that says "Interim Guidance on Halloween events." And you will see multiple pages of guidance. Basically, the take-home is you want to social distance, six feet, and suggestions like instead of lots of kids going to the door and handing them candy or having a big bowl of candy. Instead, you have a table where you can put out individual pieces of candy or you have little bags that you can put at the bottom of your driveway. There have been creative suggestions of things like a candy shoot where you can shoot candy down the stairs. Anyway that you can deliver candy in a socially distanced way would be better than the congregant hoarding of candy. And then there are suggestions outside of typical trick-or-treating. Can you do a parade or can the kids stay at your house and adults drop by and give them candy. There are 2 to 3 pages of suggestions on Halloween guidance.

Hugh:
A couple questions about masks. And what to do with kids and masks, especially those under 3. And what are the guidelines for child care centers for kids that are under two, for kids under five, and for kids five and older? Getting some concerns about daycare centers that say they are exempted. I will let you talk about those.

Betsey:
It is recommended that children under two years old do not wear a mask. Under two years old is not required or recommended. It is recommended for everybody over the age of two years old. Actually now, it is required for kids ages five and up and in K-12 it is required. So the age 2 to 5 is recommended, but not required. Under two no, 2-5 recommended if the kids can do it, five and up, required.

Hugh:
Thank you. Go ahead.

Betsey.
I don't think they can forbid them from wearing masks. But under age 2, they should not be doing that.

Hugh:
Questions about the flu. **Do you have any updates regarding the shortage of flu vaccines and maybe a shortage of syringes that might be related to that?**

Betsey:
Yes. I asked the immunization team to dig into this. Let's talk about the flu first and then we will talk about syringes. One, we have no supply issues for state supply of the flu vaccine. We have gotten almost half of our total allocation so far. The VRC, the public supply does not seem to be a problem. We have been hearing on the commercial side and private side that there has been some

problems, specifically with GFK. That all private GFK flu is on the waitlist. There does seem to be a shortage of GFK specific flu. I've also heard that Sanofi products are a little slower to the market as well. Our team is following up with them to see what we can find out. There is nothing listed on the CDC vaccination shortage page about a national shortage. This would be an instance that is unusual where the public supply is flowing more quickly than the private supply.
In terms of syringes, in order to get ready for the COVID vaccine response, because when people get the COVID vaccine, they will also get syringes and needles to go with it. The federal government -- they have contracted with a couple of syringe and needle distributors in order to support COVID, but there is not a universal shortage. If you went to your regular distributor, there are plenty of other syringe distributors where you can shift to to get them. It is just affecting one or two of the distributors, but not wholly. Just go to a different manufacturer and syringes are available. The other question was are there any tips on how to do flu clinics, like mass clinics in parking lots. And yes, there are links to great CDC tools and resources on planning drive-thru or curbside vaccination clinics. Also for satellite and off-site clinics. And that is all in the slide, not only flu vaccination clinics, but when you begin to do safe COVID vaccination clinics as well.

Hugh:
Thank you. I have a follow-up to masks for children. Bright Horizons has forbidden masks for 2-5 year olds and they require a letter from a physician for medical necessity.

Betsey:
Whoever has that question, if you have my email address, that would be great. Specifically which facility, we will follow back up with them and we will have our division for early childhood education can follow-up directly.

Hugh:
Fantastic. **I got questions in advance about back to school and back to work and one relates to the governance of health departments in school systems and providers encountering different quests for tests and returning to school notes. And schools refusing to accept rapid antigen tests and insisting on PCR. Can you comment on that?**

Zack:
That actually may be appropriate. If it is a child who was screened symptom positive and then was sent for testing and has a negative antigen test, they do require a confirmatory PCR before they can be released from isolation and be allowed to return to school. That might be an appropriate request on behalf of the school system. I think it was a broader question about we don't have a requirement for testing for all children who screen positive for symptoms, and I think there were some fairly minor changes to the toolkit that does a really nice job of spelling out steps that should be taken for kids or staff with symptoms and there are situations where an alternate diagnosis is made that might allow them to return to school without a test after 24 hours with no fever or using fever reducing medications, etc. We recognize the possibility for COVID and an ear infection, but just recognizing that there are a lot of other conditions that may cause kids to be symptomatic and if there is a recognized alternate etiology that those kids do not require a negative test to return to school. Also recognizing that no one requires a test to be released from isolation. There is the option, although we encourage testing for those with symptoms, ending of isolation and returning to school, ultimately should be done on a time-based criteria of at least 10 days from illness onset or a first positive specimen if they do not have symptoms, and 24 hours without a fever.

Betsey:

I would add that on the slide that is up, in the blue box that says “School Update”, it has the updated guidance that Zack just alluded to. Guidance on reporting and on testing and it is the current recommendation --a note thinking about performance of the antigen that even if you are a symptomatic person and you have a negative antigen, you should have a confirmatory PCR. When we learn about the performance of the antigens, that guidance might change, but there has been so much data about the limitations of the performance of this test, that that is the current guidance and it is all in that new updated school link.

Hugh:
As a reminder, you can submit questions using the Q&A feature, or if you are on the phone, you can email us at questionscovid19forum@gmail.com. I don't have any questions right now. **We do have a request that you lift up your excellent and clear policy on returning to work and not needing a negative test. So you have some fans of that policy.**

Betsey:
That was an important thing. As Zack was saying , testing -- let's talk a little bit about that. The rationale between testing in order to get people out of isolation. There were two different strategies. One was the time and symptom-based strategy. In general 10 days from the onset of symptoms as long as you are symptom-free, 10 days after the first test. In general that's the case for the vast majority of people. There are some people who may have a very severe disease or are immunocompromised, but for the vast majority of people that is a symptom based criteria. In the beginning there was a test based criteria that you must test negative to end isolation. We find that people can have residual virus in them for a long time and PCR is so sensitive and they can pick up virus long after the person is contagious. And even up until three months. The recommendation is a couple things. One, requiring a negative test to get back into school or to work is no longer recommended. It is recommended not to do it, but rather to go on the symptom based strategy. The second thing is that the recommendation is that once someone tests positive, the recommendation is not to test them at all until three months after because you could still get positives and it does not align to infectiousness. So not testing someone for 3months after a positive test. Not using a test based strategy to return to work or school is the same thing.

Hugh:
Thank you. **We got a question of how you define outbreak on campus**.

Betsey:
We use outbreak in a congregant living environment so outbreak in a nursing home, outbreak in congregant living in two or more. We use the term cluster in a non-congregant living setting, so a school setting, occupational setting, higher education setting. And that’s five and above.

Zack:
That is right.

Betsey:
Five or more. It is murky because in some institutes of higher education you have dorms and you could say those are congregant living, but for now, it’s five or more for a cluster.

Hugh:
We have a question that Zack answered, but I want to let the participants hear the answer. **Will there be guidance to test residential college students prior to returning home?**

Zack:
My answer, which I think is right, although I have to go back and check the CDC guidance, we have made that recommendation to schools that have had clusters or schools that have had issues with large numbers of cases to test students before they return home or depart. We have not made a general recommendation for predeparture testing for students in colleges or other residential settings. There is guidance on the CDC website about entry screening, so when they come back, which is not a requirement, but there is discussion about entry screening as a strategy to quickly identify or reduce introductions when kids are coming back to school.

Hugh:
Thank you very much. We do not have any more questions. Let me turn it over to our presenters to get some final comments and we can give everyone a couple of minutes back in their day.

Maggie:
As one of your peers, you guys rock this. Thank you for everything that you're doing. It is a privilege, so thank you.

Hugh:
Any other comments before you get your two days back?

Zack:
Nothing for me. Thank you.

Hugh:
We have this scheduled for two more weeks and then we need to decide if we want to keep doing these going through the rest of the fall. There is one scheduled for the 23rd so we'll get notice out about that.

Betsey:
I think we will have a lot of things as we head to the fall. Numbers are going to spike, we need to think about COVID vaccine. There will be a lot of activity going on in the next couple of months. I think it is an important piece of communication and I don't think it will be a quiet fall and winter.

Hugh:
We will tentatively plan on the second and fourth Fridays of the month. Thank you. We will keep these up. Everyone take care and have a great weekend.
[Event concluded]